APPLICATION FOR DENTAL SERVICES

Screening available Monday – Thursday 10:00 AM – 1:30 PM

Before you complete this application please understand that Fees for all dental services are separate from your "initial visit" fee. Dental pricing may vary based on the service that you receive and a deposit is required at the time of scheduling your appointment. Some dental services are no longer available such as – deep cleanings, molar root canals, dentures, crowns, partials, and night guards.

Name _____ Phone # _____

Address_____

City State Zip Code

Date of Birth_____

Total Family Income _____ Week/Month/Year Number of people in household ____

Must provide picture ID and at least two of the following:

- A current Income Tax Return,
- Your 3 most recent check stubs from your employer, or
- Applicants receiving ONLY Social Security who are unemployed and did not file an Income Tax Return, please bring your Social Security Awards letter

Do you have dental insurance? Y / N

Have you had a dental evaluation in the last 6 months? Y / N
If yes, for what? _____

What dental services are you currently seeking? (i.e. Extractions, Fillings, etc.)
_____

Acknowledgements

I understand:

- Fees for all dental services are separate from your initial visit fee. Dental pricing may vary based on the service that you receive and a deposit is required at the time of scheduling your appointment.
- Due to the great need for dental services in this area, appointments are extremely important to keep and if you miss a scheduled appointment and fail to provide at least 24 hours advance notice we may give the appointment slot to someone else who has been waiting.

Waiver of Liability for Treatment

By signing below, you acknowledge: 1. That Bethesda's volunteer healthcare providers (such as physicians, physician assistants, registered nurses, LVN, pharmacist, podiatrist, dentists, dental hygienists or any such persons who are retired or otherwise defined or included under Texas Law or Federal Law) are providing health care that is not administered for or in expectation of compensation 2. That there are limitations on you or your family's ability to recover damages from the volunteer or the Bethesda Health Clinic in exchange for your receiving health care or dental services. By signing below, I understand and acknowledge all of the items detailed on this form. And I hereby declare that all of the information I have provided to the Admissions Consultant is true and correct. I understand that any false information provided could jeopardize my eligibility as a Bethesda patient.

It is intended that this WAIVER be as broad and expansive as allowed by the law.

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Admissions Printed Name	Admissions Signature	Date

DENTAL CONDITIONS AND GUIDELINES

Please read and **initial** the following statements below signifying that you agree to the conditions set forth by Bethesda Dental Clinic.

____ I understand that I must pre-pay for each dental appointment I make.

____ I understand that there will be no **refund** on money that has been put down as a deposit towards my dental appointment.

____ I understand that if I need to cancel, I will call 24 hours ahead of time or sooner so that Bethesda may give that appointment slot to someone else who has been waiting to get in.

____ I understand that if I miss an appointment and have not called ahead, I will lose 20.00 dollars of the money that I have pre-paid for that appointment.

____ I understand that I will be dismissed from Bethesda Dental Clinic if I miss initial appointment.

____ I understand that if I am 15 minutes late after my appointment time, I will not be seen .

I _____ , Dental patient of Bethesda Dental Clinic, have read and agree to the conditions above and agree to follow these guidelines.